MALPRACTICE/PRIVILEGES QUESTIONNAIRE

PRIVACY ACT STATEMENT

- **Authority:** Title 5 USC, Sections 3109 & 3301 & Title 5 USC, Section 552a.
- **Purpose:** To obtain U.S. Civil Service Appointment.
- **Uses:** Basis for determination of qualifications and background information for the eligibility for appointment to a Civil Service position. Basis for credentialing health care providers
- **Disclosure:** Disclosure of information requested is voluntary. Failure to provide the required information will result in nonacceptability of the application.

The policy of the Department of the Army is to screen, verify, and validate statements, assertions, and documents of all applicants for health care provider positions. As part of this process, please complete the following statements (as applicable to your profession).

1. I ☐ have ☐ have not had medical liability claims, settlements, judicial, or administrative adjudication's, or any other resolved or open charges of inappropriate, unethical, unprofessional, or substandard professional practices. If affirmative, explain each incident.

2. I am ☐ licensed ☐ registered ☐ certified by the following named authority. List all current and past licensures (include issue and expiration date). Explain the circumstances surrounding the suspension or revocation of licensure previously held.

3. I ☐ have ☐ have not had my professional license denied, withdrawn, or restricted by a state or local licensing board or other authority. If affirmative, give the organization name, address, and dates invovled

Name of Organization	Address	Date

4. I ☐ have ☐ have not had professional privileges denied, withdrawn, or restricted by a health care facility. If affirmative, give the facility or organization name, address, and dates involved.

Name of Organization	Address	Date

5. I ☐ have ☐ have not resigned or otherwise dissociated myself from employment or practice after being notified of intent to start action against me for failure to properly accomplish my professional responsibilities. If affirmative, give the organization and dates involved.

Name of Organization	Address	Date

6. Are you now or have you even been required to appear before any medical or state regulating authority, regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted practitioner? ☐ Yes ☐ No
If the answer is affirmative, give a brief explanation.

7. I ☐ have ☐ have not had a history of drug or alcohol abuse/misuse. If affirmative, please explain.

8. Do you have any disease or impairment that would make your employment a hazard to yourself or others? If affirmative, please list. In addition, please provide a brief description of your health status.
9. I hereby authorize the U.S. Army to contact my malpractice carrier/licensing organizations for the purpose of verifying the above information.
• **Carrier--**
• **Address--**
• **Policy Number--**
• **Licensing Organization--**
• **Address--**
10. I hereby authorize the U.S. Army to contact the following institution (s) for the purpose of verifying the status of my current professional privileges.

Name of Organization	**Address**	**Date**

SIGNATURE OF APPLICANT
TYPE/PRINT NAME
SOCIAL SECURITY NUMBER
DATE